PERSONAL HEALTH HISTORY

THE FOLLOWING INFORMATION CONCERNING YOUR DENTAL AND MEDICAL HISTORY IS OF THE UTMOST IMPORTANCE TO US AND WILL OF COURSE BE HELD IN CONFIDENCE.

THANK YOU

FREEDMAN, FREEDMAN, & WEITMAN, D.D.S., P.C.

TODAY'S DATE: _____

PATIENT'S INFORMATION		
FIRST NAME & MIDDLE INITIAL:		
LAST NAME:		
BIRTHDAY (MM/DD/YYYY):		
SOCIAL SECURITY NUMBER:		
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME TELEPHONE NUMBER:		
WORK TELEPHONE NUMBER:		
CELL PHONE NUMBER:		
E-MAIL ADDRESS:		
SEX (PLEASE CHECK): ☐ MALE ☐ FEMALE		
MARITAL STATUS (PLEASE CHECK): ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		
NAME OF SPOUSE	SPOUSE'S BIRTHDAY(MM/DD/YYYY)	
PATIENT EMPLOYER:		
OCCUPATION:		
EMPLOYER ADDRESS:		

INSURANCE INFORMATION		
POLICY HOLDER'S NAME:	POLICY HOLDER'S EMPLOYER	
PRIMARY INSURANCE COMPANY:		POLICY #:
SECONDARY POLICY HOLDER'S NAME (IF APPLICABLE):		
SECONDARY INSURANCE COMPANY:		POLICY #:

POLICY HOLDER'S INFORMATION IS THE PATIENT THE SAME PERSON AS THE POLICY HOLDER? ☐ YES ☐ NO IF YES, SKIP THE REST OF THIS BOX IF NO, WHAT IS THE RELATIONSHIP OF THE PATIENT TO THE POLICY HOLDER? (CHECK ONE): ☐ SPOUSE ☐ CHILD ☐ OTHER		
FIRST NAME & MIDDLE INITIAL:		
LAST NAME:		
BIRTHDAY (MM/DD/YYYY):		
SOCIAL SECURITY NUMBER:		
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME TELEPHONE NUMBER:		
WORK TELEPHONE NUMBER:		
CELL PHONE NUMBER:		

IN CASE OF EMERGENCY, LIST YOUR NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

NAME:_____ **TELEPHONE #:**_____

HOW WERE YOU REFERRED TO US?_____

SIGNATURE OF PERSON RESPONIBLE FOR THE PAYMENT OF THE ACCOUNT:

_____

OVER

PERSONAL HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS:	
1. WHEN DID YOU LAST RECEIVE DENTAL TREATMENT? WHAT TYPE OF TREATMENT?	
2. WHO WAS YOUR PREVIOUS DENTIST? CITY, STATE:	
3. DO YOU HAVE DENTURES, PARTIAL DENTURES, OR BRIDGES? IF YES, WHEN WERE THEY MADE?	Y N
4. HAVE YOU BEEN HOSPITALIZED DURING THE PAST THREE YEARS?	Y N
5. HAVE YOU HAD ANY SERIOUS ILLNESSES IN THE PAST THREE YEARS? IF SO, PLEASE EXPLAIN.	Y N
6. ARE YOU UNDER A PHYSICIANS CARE? IF YES, FOR WHAT CONDITION?	Y N
7. HAVE YOU EVER WORN BRACES?	Y N
8. HAVE YOU EVER HAD GUM DISEASE?	Y N
9. HAVE YOU EVER HAD GUM SURGERY?	Y N
10. HAVE YOU EVER HAD ANY DIFFICULTY WITH ANY DENTAL WORK OR EXTRACTIONS?	Y N
11. HAVE YOU HAD ANY SURGICAL PROSTHESES? (JOINT REPLACEMENTS OR IMPLANTS)	Y* N

MEDICAL HISTORY: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?	
1. RHEUMATIC FEVER	Y* N
2. CONGENITAL HEART DEFECT	Y* N
3. ANGINA OR HEART ATTACK	Y* N
4. HEART MURMURS	Y* N
5. CONGESTIVE HEART FAILURE	Y N
6. HEART SURGERY OR PACEMAKER	Y N
7. (HIGH) OR (LOW) BLOOD PRESSURE (CIRCLE ONE)	Y* N
8. STROKE	Y* N
9. ASTHMA OR BRONCHITIS	Y N
10. EMPHYSEMA	Y N
11. HAY FEVER OR SINUSITIS	Y N
12. DIABETES	Y N
13. (HYPERTHYROIDISM) OR (HYPOTHYROIDISM) (CIRCLE ONE)	Y N
14. ANEMIA	Y N
15. DO YOU BLEED EXCESSIVELY WHEN CUT?	Y N
16. HAVE YOU HAD ANY KIDNEY INFECTIONS?	Y N
17. HAVE YOU HAD KIDNEY SURGERY?	Y N
18. HEPATITIS	Y N
19. VENEREAL DISEASE (WITHIN THE LAST 10 YEARS)	Y N
20. TUBERCULOSIS	Y N
21. HIV POSITIVE	Y N
22. AIDS	Y N
23. FREQUENT FAINTING	Y N
24. LIVER DISEASE	Y N
25. ARTHRITIS	Y N
26. ULCERS	Y N
27. GLAUCOMA	Y N
28. RADIATION THERAPY FOR CANCER	Y N
29. EPILEPSY	Y N
30. CANCER	Y N
31. DO YOU SMOKE?	Y N
32. DO YOU USE ANY OTHER FORM OF TOBACCO?	Y N
33. HAVE YOU HAD PERSISTENT PRODUCTIVE COUGH FOR THREE WEEKS OR MORE; NIGHT SWEAT; UNEXPLAINED WEIGHT LOSS; FATIGUE; FEVER.	Y N

QUESTIONS, CURRENT AMERICAN HEART ASSOCIATION STANDARDS MAY REQUIRE THAT YOU TAKE ANTIBIOTICS BEFORE EACH DENTAL APPOINTMENT. IF YOU FAIL TO DO SO WE WILL BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT UNLESS WE RECEIVE A WRITTEN EXEMPTION FROM A PHYSICIAN.

WOMEN ONLY:	
1. ARE YOU PREGNANT?	Y N

MEDICATIONS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING DRUGS OR MEDICATIONS?	
1. ANTIBIOTICS Y N	2. HIGH BLOOD PRESSURE MEDICINE Y N
3. STEROIDS OR CORTISONE Y N	4. BLOOD THINNERS Y N
5. ASPIRIN Y N	6. TRANQUILIZERS Y N
7. FOSAMAX AND/OR	8. BONIVA (BOTH FOR OSTEOPOROSIS) Y N
9. AREDIA (FOR BREAST CANCER) Y N	
10. ZOMETA (FOR PROSTATE CANCER) Y N	
PLEASE WRITE DOWN ALL OF THE PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING:	

*** IF YOU ANSWERED YES TO ANY OF THE STARRED**

ALLERGIES: DO YOU HAVE AN ALLERGY OR REACTION TO ANY OF THE FOLLOWING MEDICATIONS?	
1. LOCAL ANESTHETICS	Y N
2. PENICILLIN	Y N
3. OTHER ANTIBIOTICS	Y N
4. CODEINE	Y N
5. OTHER PAIN MEDICATIONS	Y N
6. ASPIRIN	Y N
7. BARBITURATES OR SEDATIVES	Y N
8. OTHER MEDICINES	Y N
IF YES, WHAT MEDICINES:	
9. DO YOU HAVE ANY MEDICAL PROBLEM NOT LISTED? IF YES, PLEASE EXPLAIN:	

DENTAL HISTORY:	
1. DO YOU HAVE A SPECIFIC PROBLEM THAT NEEDS ATTENTION NOW, OR WHAT PROMPTED YOU TO SEEK DENTAL CARE AT THIS TIME?	
2. HAVE YOU LOST ANY OTHER TEETH OTHER THAN WISDOM TEETH? IF YES, HAVE THEY BEEN REPLACED?	Y N Y N
3. HAVE YOU HAD SURGERY OR X-RAY TREATMENT FOR A TUMOR, GROWTH, OR OTHER CONDITION OF YOUR MOUTH OR LIPS?	Y N
4. DO YOU HAVE ANY TEETH THAT ARE SENSATIVE TO HOT, COLD, SWEETS, OR PRESSURE? IF YES, WHERE?	Y N
5. DO YOU GRIND OR CLENCH YOUR TEETH?	Y N
6. DO YOU HAVE PAIN OR DISCOMFORT DURING JAW MOVEMENT?	Y N
7. DO YOU HAVE FREQUENT HEADACHES OR PAIN IN THE AREA OF YOUR EARS?	Y N
8. HAVE YOU NOTICED ANY LOOSE, SHIFTED, OR TILTED TEETH?	Y N
9. DO YOUR GUMS BLEED EASILY?	Y N
10. HOW OFTEN DO YOU BRUSH YOUR TEETH?	
11. DO YOU USE A HARD, MEDIUM, OR SOFT BRISTLE BRUSH?	
12. DO YOU USE DENTAL FLOSS?	Y N HOW OFTEN?
13. DO YOU USE ANY OTHER HOME CARE AIDES?	Y N
14. ARE YOU FAMILIAR WITH THE TERM "DENTAL PLAQUE"?	Y N
15. DO YOU HAVE BAD BREATH?	Y N
16. DO YOU USUALLY HAVE A LOT OF CAVITIES?	Y N
17. DOES FOOD GENERALLY WEDGE BETWEEN CERTAIN TEETH?	Y N
18. ARE YOU SATISFIED WITH THE APPERANCE OF YOUR TEETH AND SMILE?	Y N